



NETWORK PROVIDER ENROLLMENT MINIMUM STANDARDS OVERVIEW

The mission of Region 3 Behavioral Health Services is to foster recovery and resiliency for individuals and their families who experience a behavioral health challenge.

Region 3 may seek additional network providers in the event that funding is available, a new service is desired, or an existing network provider leaves the Region 3 Provider Network creating a gap in service capacity.

Region 3 is a component of the Nebraska Behavioral Health System (NBHS) which is overseen by the Department of Health and Human Services (DHHS), Division of Behavioral Health (DBH), and as such, DBH retains the right, based on quality and/or safety issues, to deny approval of new practitioners, providers, and sites in the Region 3 Provider Network, and to terminate or suspend individual practitioners or providers.

Region 3 Behavioral Health Services (Region 3) shall enroll applicants into its network based on the successful completion of the Network Provider Enrollment Minimum Standards (NPEMS) process outlined in this document.

The following shall be assessed:

- 1) The Applicant's demonstration of its ability to comply with 206 Nebraska Administrative Code (NAC) Chapters 1, 4, 5, and 6 (if chapter 6 is applicable) <https://dhhs.ne.gov/Pages/Title-206.aspx>;
- 2) The Applicant must be Nationally Accredited appropriate to the organization's mission by Joint Commission (JC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or other nationally recognized accreditation organization
- 3) Adherence to the service definition(s) specific to the service(s) the Applicant desires to provide in the network (see Behavioral Health Adult Service Definitions contained in the Nebraska Continuum of Care Manual for Mental Health and Substance Use Disorders) <https://dhhs.ne.gov/Behavioral%20Health%20Documents/Continuum%20of%20Care%20Manual.pdf> and
- 4) The availability of funding Region 3 has to purchase services identified as core and necessary to meet the behavioral health needs of individuals and families who meet Region 3 clinical, financial, and lawful presence eligibility criteria.
- 5) Applicants must be enrolled as a Medicaid provider if the service provider is eligible for Medicaid funding and the service purchased by Region 3 is a covered Medicaid service. <https://www.nebraskamedicaidproviderenrollment.com/>

INITIAL ENROLLMENT OF NETWORK PROVIDERS

The decision to enroll a behavioral health provider in the Region 3 Provider Network is based on the collection of the following information:

A. COMPLETE NETWORK PROVIDER ENROLLMENT APPLICATION

B. STATE LICENSURE AND NATIONAL ACCREDITATION

Compliance with all applicable state standards and licensure requirements for program, facilities, and staff members.

1. Submit a current copy of the required licenses issued by the DHHS or the applicable local licensing authorities of competent jurisdiction which apply to the program.
 - a. Facility License
 - b. Fire Inspector/Occupancy Permit
2. National accreditation appropriate to the provider's mission
Submit documentation of national accreditation, including:
 - a. A complete copy of the most recent official accreditation report;
 - b. Documentation of the most recent official award of accreditation; and
 - c. A complete copy of the plan of correction submitted in response to the official accreditation report, if applicable.
3. Professional License and endorsements of staff members

C. ORGANIZATIONAL INFORMATION

Submit the most recent information for your organization.

1. Board of Directors
2. Organizational Chart
3. Staff List to include: Name, Title, Program, Professional License Number, NPI #, as applicable
4. W-9

CI. ON-SITE VISIT

Documented completion of an on-site visit for all providers before enrollment in the Region 3 Provider Network and service provision to any consumer receiving services funded by Region 3. The on-site visit will evaluate the site where services are provided. When the service is not a "facility-based program," the building or location visited shall be the site where the provider's organized program, clinical, financial record keeping function is established.

CII. ENROLLMENT STATUS

After the successful completion of the 12-month provisional period, the decision to retain a behavioral health provider is based on actual performance and a retention review. A regular site visit, which includes services purchased verification unit audit, programmatic review, financial review, and continued compliance with NPEMS and contract requirements, will be conducted. Continued status as a member of the Region 3 Provider Network is contingent upon the following:

1. Continued compliance with enrollment requirements, minimum standards, contract requirements, and State Regulations;
2. A review of data demonstrating the operation of the service outlined in the current contract;
3. Consumer satisfaction;
4. Compliance with information reporting and data submission to Region 3;
5. Completion of reports specified by Region 3;
6. Inclusion of consumers in development, implementation, and evaluation of services.
7. Successful annual site visits.
8. Error-Free Reporting: The provider will demonstrate accuracy in billing, utilization of the Centralized Data System, consumer service data, and other reporting requirements.

Termination of Process: The falsification of documents or information by the Network Provider or individual to Region 3 or the DBH is grounds to immediately terminate the Network Provider application process or the existing network provider approval.

NETWORK PROVIDER REQUIREMENTS WHEN SIGNING A CONTRACT TO PROVIDE BEHAVIORAL HEALTH SERVICES WITH REGION 3

	Timeframe
CDS Data Entry: Provider Location Capacity/Region 3 Funded Capacity - Waitlist Data	Weekly
Ensure that all publications or publicly released materials created, modified, or completed using funds from this agreement, including, but not limited to, media, training event flyers, and activity advertisements that results from work under this subaward include the DHHS approved federal funding acknowledgement and are submitted to REGION 3 for prior review and approval.	On-going
Staff utilization in Electronic Billing System to submit only charges to be paid with funds from DBH as well as participation in technical assistance and trainings related to use of EBS	On-going
Network Provider must complete the United States Citizenship Attestation Form for all individuals receiving Region 3 funding	On-going
Network Provider must complete a Financial Eligibility worksheet to determine Region 3 eligibility for all individuals receiving Region 3 funding	On-going
Enter timely and accurate information into the Centralized Data System for consumers funded by Region 3 to allow for data trend tracking and data driven continuous quality improvement set in the Region 3 Network Quality Improvement Plan. Ensure ongoing data input through registration/ authorization and discharge process.	Ongoing
Complete Denial/Ineligibility Report	Quarterly
Actively participate in the Regional Quality Improvement Team (RQIT)	Quarterly
Receive 42CFR Part B Training	Annually
Submit a Budget Plan for BH services for the upcoming fiscal year as specified by the Regional Budget Plan Guidelines.	Annually
Submit the following: Board of Directors/Community Board; Organizational Chart; Staff List to include Name, Title, Program, and Professional License Number, NPI number and Facility License	Annually
Certificate of Liability	Annually
Report Complaints, Grievances, and Appeals	Annually
Report Sentinel Events: In the event of death or serious injury to any Region funded consumer currently in a Region 3 funded behavioral health service, will notify REGION 3 no later than forty-eight (48) hours after the sentinel event.	Annually
Services Purchased Verification Audit	Annually
Receive Charitable Choice Training	Every 2 Years
Programmatic Fidelity Audit -Timeline Verification- Policy Review	Every 3 Years
Participate in Needs Assessments conducted by DHHS or Region 3	As requested

NETWORK PROVIDER REQUIREMENTS WHEN SIGNING A CONTRACT TO PROVIDE BEHAVIORAL HEALTH SERVICES WITH REGION 3

Network Provider will provide Region 3 with a copy of the Certificate of Liability. Insurance coverage may include, but is not limited to:

- a. Workers' compensation and employers' liability
- b. Commercial automobile liability
- c. Professional liability
- d. Medical malpractice liability
- e. Directors/officers liability
- f. Commercial general liability
- g. Umbrella/Excess liability
- h. Abuse & Molestation liability
- i. Cyber liability

Network Provider will comply with the clinical eligibility, levels of care entry and exit criteria, and assessment and service definition guidelines as contained in 206 NAC Chapters 1-5.

<https://dhhs.ne.gov/Pages/Title-206.aspx>;

Network Provider will ensure the utilization of a "no refusal" approach to admitting persons determined clinically and financially eligible to community-based BH services in the REGION 3 Behavioral Health Services Provider Network.

Network Provider will comply with the financial eligibility criteria, the fee schedule, and accept the rate schedules established by Region 3.

Network Providers will actively monitor for Medicaid eligible consumers on a monthly basis using any Medicaid provided method of the Nebraska Medicaid Eligibility System (NMES) line. (Instructions found at: <https://dhhs.ne.gov/Pages/Medicaid-Provider-Client-Eligibility-Verification.aspx>)

Network Providers will provide Medicaid eligibility and enrollment information to consumers not currently enrolled in Medicaid.

Network provider must have the capacity to provide an evaluation and assessment of the behavioral health needs of any person seeking authorization and payment for the service(s) they provide.

Network Providers will submit Certified Public Accountant (CPA) audits or unaudited financial statements to REGION 3 no later than eight months after the end of the PROVIDER'S fiscal year, as applicable

- a. If a Provider expends more than \$1,000,000 of Federal funds in a 12-month fiscal period, CPA will be engaged to conduct an audit in accordance with the Single Audit Act.
- b. If Provider expends less than \$1,000,000 of Federal funds, in a 12-month fiscal period an audit is not required but unaudited financial statements will be required to include, at the minimum, Balance Sheet and Income Statement.